Chapter 3
Assessing Current Prevention Practice

Overview

After staff have agreed on the need for change:

1. Examine whether the PPIP tools will fit your clinic's needs.
   - By reviewing what you are already doing, you can eliminate the creation of additional work.
2. Review your current system of delivery and decide what has been working well and what has not.
   - There may not be a need to change everything. Avoid the duplication of forms and documentation.
3. Acknowledge what you are doing well.
   - At this time of reflection, pause to celebrate past successes.

Establishing A Baseline

A review of current systems can provide a baseline for comparison when evaluations are conducted in the future. Use initial chart audits to document how many people are currently receiving preventive services such as screenings and counseling on identified health risks. To assess changes within the individual and group systems, determine where you are starting from as an organization. How are people working together? Do people like working here? What do patients say about your clinic? As you conduct future evaluations, you will see how effective the new system is for your clinic.

Assessing Current Prevention Activities

What preventive care do we currently provide our patients?

What percentage of those eligible are receiving preventive services?

What policies and procedures do we have in place for providing preventive services?

What forms and systems are we using?

Will the PPIP system duplicate the work we're already doing?

What services are we documenting?

Who is documenting what?

What functions do our staff currently serve in the provision of preventive care?

How does our current patient flow support or inhibit our delivery of preventive services?

How does our current physical environment support or inhibit our delivery of preventive services?

How have we managed change in the past?

What has worked? Why?

What has not worked? Why?

What can we do differently?

Assess Current Clinic Flow

Clinic Flow Worksheets

Current Clinic Flow

- Use this exercise to review your current clinic flow.
- Note which staff members perform which functions.
- Note when each service is documented.

Compare staff perceptions of current clinic flow by having them complete the worksheets. Then discuss as a group.

Sample Current Clinic Flow

Patient enters clinic for an appointment:

- All new patients complete a personal information form/medical history/insurance information provided by receptionist.
- Patient asked to wait in waiting room. Educational materials available for patient to review.
- Nurse/medical assistant/nurse assistant calls patient from the waiting area and takes patient's height, weight, blood pressure and brief history of presenting problem.
- Information is documented on a progress note and the patient is brought into the exam room.
- The patient waits for the clinician in the exam room.

Patient sees the clinician:

- The clinician documents assessment, diagnosis and services in the progress notes.
- Flow sheets are used only to track medications, weight and vital signs.

Patient exits clinic:

- Educational materials available for patient to take home.
- Follow-up information is documented on the bill.
- Receptionist makes appointment for patient's next visit.

Clinic Flow Worksheets

Current Clinic Flow

Complete these worksheets to assess your current clinic flow and identify how your clinic presently incorporates prevention activities. Specify who the patient meets and interacts with and briefly describe the nature of the interaction. Identify times when forms are completed or services are documented. (Note: Sample completed clinic flow worksheet on page 21)

Patient enters clinic for an appointment:

- How and when does your clinic identify what screening activities are up-to-date and what preventive care is indicated for your patients?
- Who does the patient see prior to the clinician? What is done and/or discussed during this interaction?
- What educational materials are available for the patient to read in the waiting area? Do staff offer/provide appropriate materials?

Patient sees the clinician:

- How does the clinician know what preventive services to offer/order?
- How is the patient's preventive status monitored over time?
- What services are documented? How and where are services documented?

Patient exits clinic:

- What kind of monitoring system is in place to follow up with off-site screenings?
- What kind of reminder system is in place to follow up with screenings or counseling that are needed but were not done at this visit?

Establishing Baseline Measures

Determine how risks are identified and how the identified risks are addressed. Assess the percentage of patients who are receiving appropriate assessments, counseling, screenings, and immunizations among those identified at risk.

Initial Chart Audits

- Determine the number of charts needed to give you a good, overall picture of clinical preventive services at your clinic. For instance, 5–10 charts for each provider, or 10–15 charts per month.
- Choose a time period to cover. Six months is often used.
- Using the appointment log from that time period, choose two morning and two afternoon appointments per day to reach the desired number for that month. Ensure you cover all days of the week (include weekend and night clinics if applicable) and include all practitioners.
- Decide which services to evaluate. You may simply start with one service, such as pap smears, for your initial assessment. In this way, you can assess each patient's chart and find it either up-to-date or not.
- There are three example chart audit forms following on pages 25–29. These range from simple to complex. Of course, you can adapt these or choose another form to better assemble the information you desire.

Simple Chart Audit

Chart #	Systematic Assessment of Risk Factors?	Initial Physical Exam?	Health History	Appropriate Screening Exams Complete?	Any Health Education Documented?	Date Client Was Seen	Age
1002	no	yes	no	no	yes	12/3/95	55
2323	yes	yes	no	no	yes	5/5/95	32
TOTALS							
	1 YES/2	2 YES/2	0 YES/2	0 YES/2	2 YES/2		

You can adapt this type of form to assess for one particular screening test and one particular educational topic (for example, a cholesterol screening test within the last five years and health education for nutrition risk).

Example 2

Adapted from the Chart Audit of the Cancer Prevention in Community Project (Carney, 1992; Dietrich, 1994)

							HEALTH SCREENING AREA					
Date of most recent visit	Age	Sex	Is Flow Sheet in Chart?	Has it been updated within 12 months?	Smoker?	Tobacco Counseling?	PSA	Guaiac	Breast Exam	Mammogram	Pap/ Pelvic	Comments
5/5/96	32	F	Y	N	N		NA	NA	4/95	NA	4/95	Prog. Notes/Lab
5/5/96	59	M	Y	Y	Y		Y	7/95	NA	NA	NA	Prog. Notes
5/5/96	42	F	N	N	N		NA	NA	NI	NA	NI	Mental illness-little attention paid to prevention

DIRECTIONS: Use information recorded on a patient's flowsheet, health history form, or most recent progress notes to complete this form. Use one line for each patient. Record the indicated demographic data in the first three columns. Complete the next nine columns as follows: "Y" indicates "yes", "NA" indicates "not applicable" "N" indicates "no" and "NI" indicates no information found. We have listed five "Health Screening Areas" with which you can begin. You should decide as a group what issues you would like to evaluate. For each patient, record the most recent date a procedure was performed, recommended or scheduled regardless of where it was done.

Example 3

Protocol for a More Complex Audit

Practice X, which has a large diabetic population, has agreed to the following minimal prevention standards:

Well Woman Care

- All women 21 and over will receive a pap smear every three years.
- All women 51 and over will receive a mammogram every year.
- All women 21 and over will receive a clinical breast exam every three years.

Immunizations

- All adults will receive a Td every 10 years.
- All adults over the age of 65 will receive a pneumovax.
- All adults 65 and over will receive a flu vaccination every year.

Population-Based Screenings

- All adult patients will have a cholesterol screen done every five years.
- All adult patients will have a glucose screening every three years.

Assessment and Counseling

- All patients will receive an initial physical exam within first year of service.
- Once a year, all adult patients will be assessed for risk related to smoking, physical activity, nutrition, alcohol, diabetes, and STD/HIV. They will be counseled, referred, screened, or treated in relation to all identified risks.

They have agreed to use the attached chart audit form (Example 3) to assess current documentation of these services. In order to compute a ratio for timely screens/ required screens, they have established patient categories as follows:

Pt.Cat.	Gender/Age	Minimal Requirements
PC1	M/F age 19–21	Td
PC2	M age 21–24	Td + Glucose
PC3	M 25–64 y.o.	Td + Glucose + Chol.
PC4	M = or > 65 y.o.	Td + Glucose + Chol. + Pneumovax + Flu
PC5	F 21–24 y.o.	Td + Glucose + Chol. + Pneumovax + Flu + CBE
PC6	F 25–50 y.o.	Td + Glucose + Chol. + CBE + Pap
PC7	F 51–64 y.o.	Td + Glucose + Chol. + CBE + Pap + Mamm.
PC8	F = or > 65 y.o.	Td + Glucose + Chol. + CBE + Pap + Mamm. + Pneumovax + Flu

The patient categories and relevant minimal requirements are used to determine "ratio of timely screens", as shown in the final column of page 2 of Example 3.

Example 3, Page 1

Chart Audit to Assess Current Level of Documentation of Clinical Preventive Services

						A = Assessment for Risk of and/or: C=Counseling/Referral/Screening/Tx of: (Circle where documented in chart within the last 12 months)											
PT	Gender	Age	Sample Date	No. Visits Last 12 Months?	Health Hx?	Smoking		Physical Actvity		Nutri-tion		Alcohol		DM		STD/ HIV	
1-GK	M	59	5/5/96	8	Yes	(A)	C	A	C	A	C	(A)	C	(A)	(C)	A	C
2-MM	F	68	6/6/96	3	Yes	(A)	C	A	C	(A)	(C)	(A)	C	A	C	A	C
3-LR	F	32	7/5/96	1	No	(A)	(C)	A	C	A	C	A	C	A	C	(A)	(C)
4-AB	F	51	5/10/96	5	Yes	(A)	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C
						A	C	A	C	A	C	A	C	A	C	A	C

Example 3, Page 2
Chart Audit

	DATE OF LAST:								CPS SCORES		
Patient	Pap	Mamm	CBE	Cholst	Glucose	Td	Pneuvx	Flu	# Linked A and C	Patient Category	Ratio Timely Screen Category Requiremt
1	–	–	–	6/95	5/95	-87	–	–	1	3	3/3 = 1
2	5/96	6/96	5/96	5/90	5/90	5/90	5/90	–	1	8	5/8 =.62
3	7/92	–	7/92	7/95	7/95	7/90	–	–	2	6	3/5 = .6
4	5/93	–	5/93	6/95	6/95	–	–	–	0	7	4/6 = .66
TOTALS FOR PATIENTS #1–25									4	–	2.88
AVERAGE OF SCORES:									1	–	.72

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